

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
Tykerb (lapatinib ditosylate)

Patient name: _____ Medicaid ID #: _____
Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____
Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____
Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____
Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR
LETTER OF MEDICAL NECESSITY TO 855-828-4992 note the new fax number**

CRITERIA:

- Patient must be age 18 or above
- Diagnosis of advanced or metastatic breast cancer whose tumor overexpresses HER2.
- Documentation of prior therapy, including the following agents:
 - An anthracycline (e.g. danorubicin, doxorubicin, epirubicin, idarubicin, or valrubicin).
 - A taxane (e.g. paclitaxel, docetaxel, or taxotere).
 - Trastuzumab.
- To be given in combination with capecitabine.

AUTHORIZATION:

Initial PA is granted for 1 year.

RE-AUTHORIZATION:

Re-authorization is granted in one-year increments with an updated letter of medical necessity.

9/20/10

<http://health.utah.gov/medicaid/pharmacy>